Medical History

Today's Date_____/_____/_____

Name_____ Birthdate_____/_____/_____

Medications

Please list any medications (including over the counter drugs and nutritional supplements such as vitamins) that you take and what condition or reason you are taking it for. If you have a prepared list you can provide that in lieu of listing you medications here.

_____

_____

Do you have any allergies to medications? Yes____ No ____ If yes, please explain:

_____

_____

General Health – Review of Systems

Do you have any problems in the following areas:

	Yes	No		Yes	No
Fever	___	___	Asthma	___	___
Excess Weight Loss or Gain	___	___	Chronic Bronchitis	___	___
Headaches	___	___	Difficulty Breathing	___	___
Seizures	___	___	Diabetes	___	___
Thyroid Disease	___	___	High Blood Pressure	___	___
Other Glandular Disease	___	___	Heart Disease	___	___
Skin Disease	___	___	Vascular Disease	___	___
Allergy/Hay Fever	___	___	Diarrhea/Constipation	___	___
Sinus Congestion	___	___	Other GI Disease	___	___
Dry Throat/Mouth	___	___	Kidney/Bladder	___	___
Arthritis	___	___	Reproductive Organs	___	___
Autoimmune Disease			Mental	___	___
(Such as Lupus, Fibromyalgia	___	___	Psychiatric	___	___
Cancer	___	___	Other – Not Listed	___	___

Please explain any yes answers: _____

_____

_____

_____